Central New York State Regional Group
August 1, 2017

WELCOME

Ending the Epidemic in New York State
The counties that make up Central NY Region
Ending the Epidemic

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
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
Aim of NY Links: To bridge the systemic gaps between HIV related services within New York State and achieve better outcomes for PLWHA through improving systems for monitoring, recording and accessing information about HIV care in NYS.

NY Links

History...

• Began in as a multi state HRSA HIV/AIDS Bureau (HAB) funded Special Project of National Significance (SPNS) – aimed at supporting the development of innovative models of HIV care.
• In 2011 HAB launched the Systems Linkages and Access to care for Populations at High Risk of HIV Infection Initiative this Initiative became NY Links
Monthly Newsletters Emailed

Dr. Jose Tiberio presented the excellent Bronx Lebanon Hospital Family Medicine Organizational Treatment Cascade at the Quality of Care Program’s Consumer Advisory Committee on Wednesday, June 14. Their cascade CI plan includes plans to train and hire community health workers and to implement a peer support program. Congratulations to Dr. Tiberio, and the NYlinks Bronx Regional Group member, Bronx Lebanon Hospital Family Medicine! Great job!

The Suffolk sub-regional group met in coordination with the Suffolk Co ETE on Friday, May 19 at United Way of Long Island. The meeting went very well and was attended by 41 individuals including several community members and staff from 18 different agencies/organizations. The highlight of the meeting was presentation of organizational cascades by Stony Brook Medicine and Hudson River HealthCare Suffolk HIV Program, and a presentation by Dan Tietz, NYSDOH AIDS Institute, on consumers fitting into the cascade. Based on a survey conducted among regional group members, the next meeting will be a meeting of the full region being discussed for the Fall.

The second meeting of the Lower Manhattan Regional Group will be on Tuesday, June 20th at Las Americas (66 Exchange Pl.) from 11:30 – 4:00 pm. The steering committee has an interactive meeting planned. This region will also be evaluating the aggregated HIV treatment cascade data and using this to establish baseline performance and next steps toward ending the epidemic in the region. There will be collaborative discussion of individual agency cascade data, priorities and improvement plans, and interactive discussions of various forms of stigma that can impact health outcomes. We’ll learn about and plan for the statewide initiative to reduce HIV (and intersectional) related stigma, measuring stigma and the tools/resources available to address findings. Hope to see you there!

Thanks to the CUNY School of Public Health and Policy for hosting the May 25 meeting. Big kudos to the full group of participants for sharing their experience with developing and using their organizational HIV treatment cascades, improvement plans and anticipated implementation challenges, working together to set new measurable goals, and sharing their experience and launching the initiative to reduce HIV and intersectional stigma across agencies in the region. A special thanks to the following individuals who planned and presented at the meeting:
- Escott Solomon (Harlem Hospital, ETE Co-Chair)
- Shruti Ramachandran (Mount Sinai – Institute of Advanced Medicine & NYlinks Steering Committee)
- Jennifer Knight (NY Presbyterian & NYlinks Steering Committee)
- Rebecca Green (Institute for Family Health & NYlinks Steering Committee)
- Lawrence Frances (FACKS & ETE Co-Chair)
- Kelly Hancock & Margaret Brown (NYSDOH AI)

Please check your email for a short survey to help us better understand how we can assist your improvement efforts. We are anxious to hear from providers and consumers alike about how we can best work together to end this epidemic by 2020. Even if you have not yet participated in activities, your response is extremely important to us! The survey link is noted below: https://www.surveymonkey.com/r/kiHlnknbb
We are planning the next Regional Group meeting for mid-September. More details will follow soon!
Goals:

- Facilitate collaboration between agencies and organizations providing HIV Services in NYS.
- Identify and assess innovative data-backed interventions for linking and retaining patients in care.
- Integrate these innovations into existing networks and services statewide.
- Coordinate existing data systems within NYS to better analyze and improve linkage and retention.
- Establish clear performance measurements to allow for routine and accurate monitoring of HIV care across NYS.
- Develop plans to sustain regionalized linkage and retention efforts in NYS.
New York State Cascade of HIV Care, 2015

Persons Residing in NYS† at End of 2015

- Estimated HIV-Infected Persons‡: 122,000
- Persons Living w/Diagnosed HIV Infection: 112,000 (92% of infected)
- Cases w/any HIV care during the year*: 90,000 (74% of infected, 81% of PLWDH)
- Cases w/continuous care during the year**: 74,000 (61% of infected, 66% of PLWDH)
- Virally suppressed (n.d. or <200 copies/ml) at test closest to end-of-year: 75,000 (62% of infected, 67% of PLWDH, 83% of cases w/any care)

†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.
‡ 8% were infected and unaware (CDC estimate)

* Any VL, CD4, genotype test during the year; ** At least 2 tests, at least 91 days apart
Cascade of HIV Care: Binghamton Ryan White Region

Persons Residing in the Binghamton Ryan White Region† at End of 2015 (excludes prisoner cases)

- Estimated HIV-Infected Persons‡: 560
- Persons Living w/Diagnosed HIV Infection: 490 (87% of infected)
- Cases w/any HIV care during the year*: 370 (67% of infected, 76% of PLWDHI)
- Cases w/continuous care during the year**: 300 (53% of infected, 61% of PLWDHI)
- Virally suppressed (n.d. or <200 copies/ml) at test closest to end-of-year: 330 (59% of infected, 67% of PLWDHI, 88% of cases w/any care)

†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.
‡ 13% were infected and unaware (CDC estimate)
* Any VL, CD4, genotype test during the year; ** At least 2 tests, at least 91 days apart
Cascade of HIV Care: Binghamton Ryan White Region

Persons Residing in the Binghamton Ryan White Region†, at End of 2014 (excludes prisoner cases)

- Estimated HIV Infected Persons: 500
- Persons Living w/ Diagnosed HIV Infection: 500 (87% of infected)
- Cases w/any HIV Care during the year*: 400 (72% of infected, 83% of PLWDHI)
- Cases w/continuous care during the year**: 300 (57% of infected, 66% of PLWDHI)
- Virally suppressed (n.d. or ≤200/ml) at test closest to end-of-year: 300 (62% of infected, 72% of PLWDHI, 87% of cases w/any care)

* Any VL or CD4 test during the year; ** At least 2 tests, at least 3 months apart

†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.
Cascade of HIV Care: Syracuse Ryan White Region
Persons Residing in the Syracuse Ryan White Region† at End of 2015 (excludes prisoner cases)

- Estimated HIV-Infected Persons‡: 2,490
- Persons Living w/Diagnosed HIV Infection: 2,170 (87% of infected)
- Cases w/any HIV care during the year*: 1,760 (70% of infected 81% of PLWDHI)
- Cases w/continuous care during the year**: 1,510 (61% of infected 70% of PLWDHI)
- Virally suppressed (n.d. or <200 copies/ml) at test closest to end-of-year: 1,550 (62% of infected 71% of PLWDHI 88% of cases w/any care)

†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.
‡ 13% were infected and unaware (CDC estimate)
* Any VL, CD4, genotype test during the year; ** At least 2 tests, at least 91 days apart
Cascade of HIV Care: Syracuse Ryan White Region
Persons Residing in the Syracuse Ryan White Region†, at End of 2014 (excludes prisoner cases)

- Estimated HIV Infected Persons: 2,400
- Persons Living w/ Diagnosed HIV Infection: 2,100 (87% of infected)
- Cases w/any HIV Care during the year*: 1,700 (71% of infected, 82% of PLWDHI)
- Cases w/continuous care during the year**: 1,400 (58% of infected, 66% of PLWDHI)
- Virally suppressed (n.d. or ≤200/ml) at test closest to end-of-year: 1,500 (63% of infected, 72% of PLWDHI, 88% of cases w/any care)

* Any VL or CD4 test during the year; ** At least 2 tests, at least 3 months apart
†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.
ETE Dashboard- How are we doing?
ETE Metrics
NYS Progress to End the AIDS Epidemic by the end of 2020

NEW HIV INFECTIONS (INCIDENCE)
Reduce the number of estimated new HIV infections to

Target 750
Actual 2,436

NEW HIV DIAGNOSES
Reduce the number of new HIV diagnoses by 55% to

Target 1,515
Actual 3,155

LINKAGE TO CARE
Increase the percentage of newly diagnosed persons linked to HIV medical care within 30 days of diagnosis to at least

Target 90%
Actual 73%

Source: Actual values based on NYS HIV Surveillance System as of January 2017
NYS DOH AIDS Institute, Division of HIV/STD Epidemiology, Evaluation & Partner Services
Website: etedashboardny.org

**RECEIVING ANY CARE**
Increase the percentage of persons living with diagnosed HIV infection who receive any care to

- **Target**: 90%
- **Actual**: 81%

**VIRAL SUPPRESSION - ALL DIAGNOSED**
Increase the percentage of persons living with diagnosed HIV infection (PLWDHI) with suppressed viral load to

- **Target**: 85%
- **Actual**: 67%

**VIRAL SUPPRESSION - RECEIVING ANY CARE**
Increase the percentage of PLWDHI who receive care with suppressed viral load to

- **Target**: 95%
- **Actual**: 83%

Source: Actual values based on NYS HIV Surveillance System as of January 2017
NYS DOH AIDS Institute, Division of HIV/STD Epidemiology, Evaluation & Partner Services
Website: etedashboardny.org

**HIV STATUS AWARE**
Increase the percentage of people living with HIV who know their serostatus to at least

- **Target**: 98%
- **Actual**: 92%

**CONCURRENT AIDS DIAGNOSIS**
Reduce the proportion of persons with a diagnosis of AIDS within 30 days of HIV diagnosis to

- **Target**: 15%
- **Actual**: 19.4%

**TIME TO AIDS**
Reduce the percentage of persons newly diagnosed with HIV who progress to AIDS in 2 years by 50% to

- **Target**: 5.1%
- **Actual**: 6.8%

Source: Actual values based on NYS HIV Surveillance System as of January 2017
NYS DOH AIDS Institute, Division of HIV/STD Epidemiology, Evaluation & Partner Services
Quality Improvement
What is Quality Improvement and why is it important?

Quality Improvement consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups.

If you cannot measure it... You cannot improve it.
Drilling down your data:

**FOUR STEPS TO DRILLING DOWN DATA**

1. **IDENTIFY PATIENTS WHO ARE NOT RETAINED**
   - Compile a list of patients who have not been seen during the time period used to define retention. Remove those from the list who meet the exclusion criteria.

   **EXAMPLE:**
   - **EXCLUSION CRITERIA:** The patient has died, transferred care, is incarcerated, or has been admitted to a long-term or residential care facility. These patients should be removed from your denominator.
   - **1012** Total patient case load
   - **56** Original list of not-retained patients
   - **19** Excluded: known status (e.g., died, transferred care, incarcerated)
   - **37** Remaining list to drill down

   The remaining group of patients are those to include in the drill down process.

2. **ASSESS REASONS FOR NON-RETENTION**
   - For those patients not retained, conduct an assessment of the factors causing absences from care. Multidisciplinary provider teams should review all available information from patient records as needed to identify any barriers to care, competing patient concerns, and other reasons for non-retention.

   **EXAMPLE:**
   - **MULTIDISCIPLINARY TEAM MEMBERS:** Case managers, patient navigators, pharmacists, nurses, physicians, others involved.
   - **PATIENT RECORDS:** Medical records, case manager or patient navigator notes, emergency room records, correctional facility records.

3. **CREATE A TABLE**
   - Compile all the identified reasons for non-retention and tally the number of patients experiencing each. This table will be used to prioritize areas in need of improvement and to develop targeted interventions.

   **EXAMPLE:**
   - **KEEP IN MIND:** Patients grouped in the same category may have different reasons for experiencing that difficulty. For example, patients experiencing issues with transportation may not be able to pay for fares, may live too far from available transit, etc. Individualized solutions will likely be required for each patient.

<table>
<thead>
<tr>
<th>BARRIER</th>
<th>NUMBER OF PATIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRANSPORTATION</td>
<td>35</td>
</tr>
<tr>
<td>HOUSING INSTABILITY</td>
<td>11</td>
</tr>
<tr>
<td>INSURANCE</td>
<td>2</td>
</tr>
<tr>
<td>DISCLOSURE ISSUES</td>
<td>15</td>
</tr>
<tr>
<td>REFUSES TREATMENT</td>
<td>2</td>
</tr>
</tbody>
</table>

4. **DEVELOP A TARGETED FOLLOW-UP PLAN**
   - Using the data from steps 2 and 3, identify the barriers that are most critical to patient health and that affect the most patients. Develop a plan to address these issues. Consider prioritizing your follow-up strategies by examining the needs of key populations or by looking at health indicators such as average viral load (see Prioritization Strategies).

   **EXAMPLE:**
   - 1. One clinic identified incorrect contact information as a major barrier to retention among its patient population. Staff searched Medicaid and pharmacy records for updated contact information and visited the patient’s home if they were unable to locate the individual through other means.
   - 2. This clinic also identified transportation as a barrier to retention for one patient with a very high viral load. Staff members arranged transportation to the clinic for this patient, which proved important in engaging the patient in care (see HIVQUAL Brief 11, Improving Patient Retention in Western New York for more information).
Resource:

National Quality Center (NQC)-
http://nationalqualitycenter.org
UHS Primary Care - Binghamton
Infectious Disease Clinic HIV Cascade of Care for 2016

- **Viral Load Suppression**: 100% (n=245)
- **Prescribed ART**: 89.8% (n=220)
- **Active**: 98.6% (n=217)
- **Viral Load Suppression**: 91.4% (n=201)

Data Source: EMR

- Viral Load Suppression: # of active patients with viral load < 200 copies/ml at last test
- Prescribed ART: # of active patients who have been prescribed ART
- Active: # of HIV (+) patients seen at least once in the past 12 months at MVHS ID Clinic
- Prescribed ART: # of HIV (+) patients seen in the past 12 months anywhere in the MVHS organization
Infectious Disease Clinic Newly Diagnosed HIV Cascade of Care for 2016

- **Total New Diagnoses**: Total number of newly diagnosed patients
- **Internal DX**: Number of newly diagnosed patients within MVHS organization
- **Linked to Care**: Number of internally new diagnosed patients linked to care within 3 days
- **Prescribed ART**: Number of internally new diagnosed patients who were prescribed ART
- **Viral Load Suppression**: Number of internally new diagnosed patients with viral load less than 200 copies/mL at last test

Data Source: EMR

- **Total New Diagnoses**: 8 (100%)
- **Linked to Care**: 4 (50%)
- **Prescribed ART**: 3 (75%)
- **Viral Load Suppression**: 2 (66.7%)
Infectious Disease Clinic Newly Diagnosed HIV Cascade of Care for 2016

- Newly Diagnosed
- Linked to Care within 30 days
- Linked to Care within 3-5 days
- Prescribed ART
- Viral Load Suppression

Data Source: EMR
The Living Cascade
GET TESTED. TREAT EARLY. STAY SAFE.

Let’s End AIDS, Central NY.
QOC/Cascade Building Questions
Welcome to NY Links

NY Links focuses on improving linkage to care and retention in care and supports the delivery of routine, timely, and effective care for Persons Living with HIV/AIDS (PLWHA) in New York State. We also bridge systemic gaps between HIV-related services in order to achieve better outcomes for PLWHA through improving systems for monitoring, recording, and accessing information about HIV care in NYS. We use a regional approach, utilizing the learning collaborative model, to fortify the links holding together communities of practice, and the links grounding them in the communities of consumers they serve.

New York Links was created through a HRSA HIV/AIDS Bureau (HAB)-sponsored Special Projects of National Significance (SPNS). Since September of 2015 it is under the Governor’s Ending the Epidemic Initiative through the NYSDOH AIDS Institute.

+ New York Links Ryan White Conference Presentations

+ New York Links Poster Presentations at the National Ryan White HIV/AIDS Conference

New York State Ending the Epidemic Initiative

On June 29, 2014, Governor Andrew M. Cuomo detailed a three-point plan to move us closer to the end of the AIDS epidemic in New York State. The goal is to reduce the number of new HIV infections to just 750 (from an estimated 3,000) by 2020 and achieve the first ever decrease in HIV prevalence in New York State.

The three-point plan:

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

2. Links and retains persons diagnosed with HIV in health care to maximize virus suppression so they remain healthy and prevent further transmission.

3. Facilitates access to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to keep them HIV negative.

Ending the Epidemic (ETE) in New York State will maximize the availability of life-saving, transmission-interrupting treatment for HIV, saving lives and improving the health of New Yorkers. It will move New York from a history of being the most HIV-positive in the country to a future where you cannot get HIV.
I want to hear from you!

- Interested in hosting a CNY NYLinks meeting in your area?
- Suggestions on future meeting topics?
- Need technical assistance on Quality Improvement?

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WHAT’S COMING UP?

September 14th, Brooklyn Regional NYLinks meeting

September 20th, Northeastern NY Regional meeting

September 28th, McPETE Collective Meeting

October 25th Queens Regional Group Meeting
Contact Information

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